suggestions will produce little real benefit to the taxpayer.

LAURENCE GERLIS

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SIR,—In commenting on Dr R A Keable-Elliott's "Talking Point" (22 September, p 749) may I widen the subject somewhat? Dr Keable-Elliott's analysis of the "nonsense" of the present prescription charge situation and his proposals for rationalisation are, as one would expect, a fair analysis and a sound solution.

In his telling series of anecdotal examples, however, he misses one which I believe is very germane: "Dr X prescribes profusely, so that patients on his list (if not exempt) who consult him obtain quite a lot of drugs—and pay charges accordingly. Dr Y, on the other hand uses a prescription pad less readily, but has a higher incidence of referral of patients to the neighbouring outpatient department than does Dr X."

Neither of them knows this, and even if they did neither has much idea—because he has never been instructed—whether, taking year with year, Dr X's system is more costly than Dr Y's or vice versa. This state of affairs is not, of course, limited to general practitioners or to prescribing. Mr A insists that his hernia patients must remain in hospital for eight days, whereas Mr B discharges his in 24-48 hours—but inevitably with heavier involvement of family doctor and district nurse.

It is an awesome prospect, but if we are really to be serious in talking health service economics and economies is it not true that all NHS doctors (and possibly students) should have some education in this subject? After all, a large proportion of the total NHS cost arises from the decisions of clinicians—in both career and training grades. Is it heretical to suggest that when weighing up what are the therapeutic possibilities for a patient or a group of patients, the clinician should have in his mind some idea of the relative costs of these possibilities?

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Points

Medical confidentiality and the law

Dr BRIAN KIRMAN (London SW16 2HS) writes: Dr Michael Ryan (15 September, p 648) . . . says that in the Soviet Union a medical worker cannot refuse to give evidence as a witness in the judicial process. He must know that this is exactly the situation in this country. The medical practitioner, like any other witness, swears to tell "the whole truth." Moreover, medical notes are in no sense the doctor's private property. These must be made available if the Court so requires. Consequently some psychiatrists here have considered keeping a separate file of genuinely private notes; but this is clearly impracticable as a routine. Furthermore, the recent rash of public inquiries with semi-judicial status has involved much public ventilation of "private" medical records and evidence. . . .

Herpes zoster

Dr VERONIQUE MOENS (Royal Berkshire Hospital, Reading) writes: Professor A P Waterson (8 September, p 566) comments on the rarity of zoster virus infections during pregnancy. I agree that there are very few, but they are certainly not restricted to 13 cases. Recently I had shingles at 17 weeks' pregnancy, and I do not think that this was a recorded case. . . . I was delivered of a normal and very healthy daughter, now 5 months old. Clinically there have been no problems, and although the baby was said to be small on ultrasound her birth weight was 3320 g and delivery was at the expected date. I personally think that there are a lot more such cases than are recorded, but as they are benign no great attention is paid to them.

Dr K M HUNTINGTON (London SW3 6PX) writes: . . . Professor A P Waterson (8 September, p 564) says that herpes zoster in early pregnancy is rare, with only 13 recorded cases. I would like to report a patient aged 38 who developed herpes zoster on 18 December 1978. The first day of her last period was 7 November. This was her first pregnancy and she delivered normally on 12 August. Her baby daughter weighed 3740 g and seems normal in every respect. . . .

Postprandial cardiac arrests?

Dr I N FINDLAY (Renfrew PA4 8UF) writes: Minerva comments (15 September, p 678) on an analysis of cardiac arrests.[1] The two peak periods, 1-3 pm and 6-9 pm, are postprandial. Could the ingestion of hospital food be a cause?

[1] Eltringham, R J, and Dobson, M B, *British Journal of Anaesthesia*, 1979, **51**, 72.

Olympics for the handicapped

Dr J R MIRREY (Redhill, Surrey RH1 6JN) writes: In your leading article (22 September, p 688) you gave coverage to the "Transplant Olympics," which took place the previous month, with 200 competitors. . . . By a coincidence international games were also held the previous month for the amputees, the visually handicapped, and sufferers from cerebral palsy, with 430 entrants; but this was given no coverage despite of the fact that these people, though handicapped, gave some remarkably fine performances. The javelin, with defective muscle control, the high jump, when it cannot be seen, and running 100 metres with one leg are real achievements by any standards; and as 1981 is to be the International Year for Disabled Persons can we please have more coverage of this whole subject?

Mechanical aids to ventilators for use in the field

Dr O P DINNICK (Association of Anaesthetists Liaison Officer with British Standards Institution, Middlesex Hospital, London W1N 8AA) writes: Dr M G Harries's (18 August, p 426) reference to "international standards" for mechanical oxygen-powered ventilators may be misunderstood and merits clarification. The major paper to which he refers does indeed use the word "standards" in its title but it . . . covers many aspects of cardiopulmonary resuscitation . . . devoting barely a column to oxygen-powered mechanical breathing devices and not being a standard (as the term is commonly understood) for such equipment. While many of the recommendations in this important document are indeed widely accepted, some of the requirements for oxygen-powered devices, especially in relation to external cardiac massage (ECM), are debatable. For example, one of the requirements approvingly quoted by Dr Harries is—in his words—"that a ventilator triggered by hand is the *only* device that is acceptable." While I agree that pressure-cycled mechanical ventilators are far from ideal when ECM is also required, a good case can be made for using time-cycled devices. . . .

An International Standard for these devices has not so far been published by the International Standard Organisation (ISO), but one is being prepared by an ISO Technical Committee and the corresponding British Standards Institution committee.

Hazards of glazed pottery

A J CILLIERS (ICI South Africa (Pharmaceuticals) Limited, Johannesburg) writes: Your expert's answer to the query about the safety of glazed pottery for eating and drinking vessels sounds very reassuring (1 September, p 539). I am sure that he is correct if he is referring to commercially made pottery in the United Kingdom. However, in various other countries pottery is fired with low-temperature lead glazes which are known to have caused lead poisoning. This has been reported in the United States of America following the purchase of pottery by the wayside in Mexico on holiday, and I have been personally involved in a case of a similar nature following the purchase of pottery in Mozambique.

Oesophagus with an E?

Dr THOMAS B HUGH (Department of Surgery, St Vincent's Hospital, Sydney, Australia) writes: I wonder whether British gastroenterologists could be persuaded when referring to the gullet to adopt the spelling esophagus. Transatlantic variations in the spelling of this word are a nuisance to British authors wishing to publish in North America, as manuscripts, illustrations, and legends must be pruned carefully of redundant Os, a particularly tricky task when some are buried in compound words such as gastro-oesophageal (incidentally, is not "gastroesophageal" neater?) As a more or less impartial observer from the Antipodes, I despair of ever persuading the Americans to add an "o," whereas British commonsense must surely see the value of submitting national pride to the interests of uniformity. There are, of course, other practical precedents for dropping the "o"—for example, economy, ecology, and ecumenical. . . . The *Oxford English Dictionary* gives approval to the alternative use of E for OE (including for esophagus) only when Greek-derived words have come into English through Romanic languages; oesophagus comes to us via the old French ysophague, and was ysophagus in fourteenth-century England.

Correction

Neonatal care

In the letter by Dr T H Hughes-Davies (8 September, p 609) we regret that "470 g" in the last sentence of the first paragraph is a misprint for "740 g."

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